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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **DIANA J. LEMKE** **aka DIANA JOAN LEMKE** 3082 Meyers Road Camino, California 95709 **Registered Nurse License No. 332999** Respondent.	Case No. 2013-875 **A C C U S A T I O N**

Louise R. Bailey, M.Ed., R.N. ("Complainant") alleges:

PARTIES

1. Complainant brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

Registered Nurse License

2. On or about September 30, 1981, the Board issued Registered Nurse License Number 332999 to Diana J. Lemke aka Diana Joan Lemke ("Respondent"). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2014, unless renewed.

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JURISDICTION

3. Business and Professions Code ("Code") section 2750 provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

5. Code section 118, subdivision (b), provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued, or reinstated.

STATUTORY PROVISIONS

6. Code section 2761 provides, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

REGULATORY PROVISIONS

7. California Code of Regulations, title 16, section 1442, states:

> As used in Section 2761 of the code, "gross negligence" includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life.

8. California Code of Regulations, title 16, section 1443, states:

> As used in Section 2761 of the code, "incompetence" means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

COST RECOVERY

9. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

Drugs at Issue

- **Fentanyl,** is an Opiate which is classified as a Schedule II controlled substances pursuant to Health and Safety Code section 11055, subdivision (c)(8), and is a dangerous drug within the meaning of Code section 4022.
- **Dilaudid** , a brand of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055, subdivision (b)(1)(j).

BACKGROUND INFORMATION

10. Between on or about April 23, 2011, and April 24, 2011, Respondent worked as a registered nurse in the Emergency Department at Sutter Roseville Medical Center ("SRMC") in Roseville, California.

11. On or about April 23, 2011, an elderly patient ("Patient A") presented to the SRMC Emergency Department with severe pain from a fall. Respondent was assigned as Patient A's primary nurse. Respondent triaged Patient A; however, she did not record his body weight.

12. Respondent documented that on April 23, 2011, at 11:58 p.m., she administered Dilaudid 1 mg. slow IVP to Patient A. Respondent did not document Patient A's vital signs, including oxygen saturation, prior to or after administering the Dilaudid.

13. Respondent subsequently received a verbal order from the physician to administer Fentanyl 100 mcg. to Patient A. Respondent did not repeat the physician's order back to the physician and did not document that the order was verbal or that she verified the medication, dosage or the manner in which it was to be administered.

14. On or about April 24, 2011, at 1:20 a.m., Respondent administered Fentanyl 100 mcg IVP to Patient A. Respondent documented, "0125 pt desated and NRM applied on 100%". Respondent did not document Patient A's vital signs, further nursing intervention, a patient assessment, whether Patient A was on a cardiac monitor, or whether his oxygen saturation was being monitored. Before leaving Patient A, Respondent explained to his family members that Patient A's oxygen saturation level needed to be monitored, and told them they needed to get help if it dropped below a certain number.

15. Shortly after Respondent left Patient A, his family member alerted another nurse that something did not appear right. The nurse found that Patient A's oxygen levels had dropped, his eyes rolled to the back of his head and he was losing consciousness. The nurse placed him on oxygen, and stabilized him. Respondent, seeing that another nurse had intervened, did not assist, but instead documented at or about 1:33 a.m. that, "pt placed on 4l/nc and sweems [sic] to be maintaining 02 saturation". Respondent did not document an assessment of Patient A, his level of consciousness, vital signs, or oxygen saturation. Respondent did not document any assessment of Patient A or his vital signs again until approximately 4:14 a.m.

16. When questioned later about the incident, Respondent claimed that she administered Fentanyl to Patient A over a ten minute period, contrary to her documentation that, after receiving Fentanyl at 1:20 a.m., the patient desated at 1:25 a.m.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

17. Respondent is subject to discipline pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that between on or about April 23, 2011, and April 24, 2011, while working as a registered nurse at Sutter Roseville Medical Center in Roseville, California, Respondent committed acts constituting gross negligence within the meaning of the California Code of Regulations, title 16, section 1442, as follows and as more fully set forth in paragraphs 10 through 16, above:

a. Respondent failed to question the physician's order to administer Fentanyl 100 mcg. to Patient A, and failed to clarify with the physician the appropriate dosage.

b. Respondent intravenously administered Fentanyl 100 mcg. soon after administering another opiate intravenously, Dilaudid 1 mg., without adequate monitoring or supervision.

SECOND CAUSE FOR DISCIPLINE

(Incompetence)

18. Respondent is subject to discipline pursuant to Code section 2761, subdivision (a)(1), on the grounds of unprofessional conduct, in that between on or about April 23, 2011, and April 24, 2011, while working as a registered nurse at Sutter Roseville Medical Center in Roseville, California, Respondent committed acts constituting incompetence within the meaning of the California Code of Regulations, title 16, section 1443, by failing to evaluate the effectiveness of the nursing care plan through observation of Patient A's physical condition and behavior, signs and symptoms of illness, and reactions to treatment, as follows and as more fully set forth in paragraphs 10 through 17, above:

a. Respondent failed to respond appropriately to a physician's verbal order.

b. Respondent inappropriately delegated monitoring of Patient A to his family members.

c. Respondent inadequately assessed and/or documented assessments of Patient A.

d. Respondent failed to appropriately monitor a sedated patient.

THIRD CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

19. Respondent is subject to discipline pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, in that between on or about April 23, 2011, and April 24, 2011, while working as a registered nurse at Sutter Roseville Medical Center in Roseville, California, Respondent demonstrated unprofessional conduct, as set forth in paragraphs 10 through 18, above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 332999, issued to Diana J. Lemke aka Diana Joan Lemke;

2. Ordering Diana J. Lemke aka Diana Joan Lemke to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: April 8, 2013

LOUISE R. BAILEY, M.ED., R.N.
Executive Officer
Board of Registered Nursing
State of California
Complainant

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